

## **Table of Contents**

**State/Territory Name: Nebraska**

**State Plan Amendment (SPA) #: 20-0013**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Centers for Medicare & Medicaid Services  
Center for Medicaid & CHIP Services  
233 North Michigan Ave., Suite 600  
Chicago, Illinois 60601



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**Financial Management Group**

Jeremy Brunssen, Interim Medicaid Director  
Division of Medicaid & Long-Term Care  
Nebraska Department of Health & Human Services  
301 Centennial Mall South  
Lincoln, NE 68509

RE: TN 20-0013

Dear Mr. Brunssen:

We have reviewed the proposed Nebraska State Plan Amendment (SPA) to Attachment 4.19-B, NE-20-0013, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on September 30, 2020. This plan amendment increases rates for outpatient and professional services.

Based upon the information provided by the State, we have approved the amendment with an effective date of July 1, 2020. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Blake Holt at (415) 744-3754 or [blake.holt@cms.hhs.gov](mailto:blake.holt@cms.hhs.gov).

Sincerely,



Todd McMillion  
Director  
Division of Reimbursement Review

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>  <b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>	1. TRANSMITTAL NUMBER: NE 20-0013	2. STATE Nebraska
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE July 1, 2020	

5. TYPE OF PLAN MATERIAL (*Check One*):

NEW STATE PLAN                       AMENDMENT TO BE CONSIDERED AS NEW PLAN                       AMENDMENT


COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate Transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT: a. FFY 2020                      \$1,888,933 b. FFY 2021                      \$7,797,374
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Att. 4.19-B, Item 1, Pg 1; Item 2a, Pgs 1&4; Item 2c, Pg 4; Item 3, Pgs 1&2; Item 4b, Pgs 1-3; Item 4c, Pg 1; Item 5, Pgs 1 &2; Item 6a, Pg 1; Item 6b, Pg 1; Item 6c, Pg 1; Item 7, Pg 1; Item 7c, Pg 1; Item 9, Pgs 1&5; Item 10, Pg 1; Item 11a, Pg 1; Item 11b, Pg 1; Item 11c, Pg 1; Item 12b; Item 12c; Item 12d; Item 13b, Pg 1; Item 13d, Pg 1a; Item 20, Pg 1; Item 21, Pg 1; Item 26; and Item 27	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):  Att. 4.19-B, Item 1, Pg 1; Item 2a, Pgs 1&4; Item 2c, Pg 4; Item 3, Pgs 1&2; Item 4b, Pgs 1-3; Item 4c, Pg 1; Item 5, Pgs 1 &2; Item 6a, Pg 1; Item 6b, Pg 1; Item 6c, Pg 1; Item 7, Pg 1; Item 7c, Pg 1; Item 9, Pgs 1&5; Item 10, Pg 1; Item 11a, Pg 1; Item 11b, Pg 1; Item 11c, Pg 1; Item 12b; Item 12c; Item 12d; Item 13b, Pg 1; Item 13d, Pg 1a; Item 20, Pg 1; Item 21, Pg 1; Item 26; and Item 27

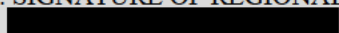
10. SUBJECT OF AMENDMENT:  
SFY21 Outpatient Provider Rates

11. GOVERNOR'S REVIEW (*Check One*):

GOVERNOR'S OFFICE REPORTED NO COMMENT                       OTHER, AS SPECIFIED:  
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED                      Governor has waived review  
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO:  Dawn Kastens Division of Medicaid & Long-Term Care Nebraska Department of Health & Human Services 301 Centennial Mall South Lincoln, NE 68509
13. TYPED NAME: Jeremy Brunssen	
14. TITLE: Interim Director, Division of Medicaid and Long-Term Care	
15. DATE SUBMITTED: September 30, 2020	

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED: 9/30/2020	18. DATE APPROVED: 12/18/2020
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/2020	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Todd McMillion	22. TITLE: Director, Division of Reimbursement Review

23. REMARKS:  
Pen and ink concurrences: 10/29/20: Box 7 : FY20 from "\$1,888,933" to "\$62,056", FY21 from "7,797,374" to "\$256,161"; 12/09/20: Boxes 8 and 9: adding "Item 7, page 1a" and "Item 13d, page 1b." 12/14/20: Box 6 from blank to "42 CFR 447 Subpart F"

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

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When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Except for Clinical Laboratory services and Injectable Drugs, the agency's rates were set as of July 1, 2020, and are effective for services on or after that date. All rates are published at: <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the fee schedule for the specific program.

The fee schedule amounts for Injectables are based on 100% Medicare Drug fee schedule. The Department shall update the Injectables Fee Schedule using the most current calendar update as published by the Centers for Medicare and Medicaid Services. Injectable medications approved by the Medicaid Medical Director but not included on the Medicare Drug Fee Schedule will be reimbursed at the estimated acquisition cost (EAC) used to reimburse pharmacy claims.

The agency's fee schedule rate was set as of July 1, 2020 and is effective for services provided on or after that date.

Payment methods for each service are defined in Attachment 4.19-B, Methods and Standards for Establishing Payment Rates, as referenced below.

<b>Service</b>	<b>Attachment</b>	<b>Effective Date</b>
ANESTHESIA	ATTACHMENT 4.19-B Item 6d	July 1, 2020
PRTF	ATTACHMENT 4.19-A Page 30	July 1, 2020

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TN # NE 20-0013

Supersedes

TN # NE 19-0011

Approval Date 12/18/2020 Effective Date July 1, 2020 \_\_\_\_\_

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State Nebraska  
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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Payment for Outpatient Hospital and Emergency Room Services: For services provided on or after July 1, 2020, the Department pays for outpatient hospital and emergency services with a rate which is the product of:

1. Eighty six percent (86%) of the cost-to-charges ratio from the hospital's latest Medicare cost report (Form CMS-2552-89, Pub. 15-II, Worksheet C); multiplied by
2. The hospital's submitted charges on Form CMS-1450 (UB-04).

The effective date of the cost-to-charges percentage is the first day of the month following the Department's receipt of the cost report.

Providers shall bill outpatient hospital and emergency room services on Form CMS-1450 (UB-04) in a summary bill format. Providers shall not exceed their usual and customary charges to non-Medicaid patients when billing the Department.

Exception: All outpatient clinical laboratory services must be itemized and identified with the appropriate HCPCS procedure codes. The Department pays for clinical laboratory services based on the fee schedule determined by Medicare.

Payment for Outpatient Hospital and Emergency Room Services Provided by Critical Access Hospitals: Effective for cost reporting periods beginning after July 1, 2016, payment for outpatient services of a CAH is one hundred percent (100%) of the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except that the following principles do not apply: the lesser of costs or charges (LCC) rule and the reasonable compensation equivalent (RCE) limits for physician services to providers. Nebraska Medicaid will adjust interim payments to reflect elimination of any fee schedule methods for specific services, such as laboratory services, that were previously paid for under those methods. Payment for these and other outpatient services will be made at one hundred percent (100%) of the reasonable cost of providing the services. Professional services must be billed by the physician or practitioner using the appropriate physician/practitioner provider number, not the facility's provider number. To avoid any interruption of payment, Nebraska Medicaid will retain and continue to bill under existing provider numbers until new CAH numbers are assigned.

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TN # NE 20-0013

Supersedes

Approval Date 12/18/2020 Effective Date July 1, 2020

TN # NE 19-0011

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State Nebraska  
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

---

OUTPATIENT HOSPITAL SERVICES

Nebraska Medicaid pays for covered psychiatric partial hospitalization services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Mental Health and Substance Use Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
  - a. The unit value multiplied by the conversion factor;
  - b. The invoice cost (indicated as "IC" in the fee schedule);
  - c. The maximum allowable dollar amount; or
  - d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of psychiatric partial hospitalization services. The agency's fee schedule rate was set as of July 1, 2020 and is effective for psychiatric partial hospitalization services provided on or after that date. All rates are published on the agency's website at <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the fee schedule for the specific program and year.

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TN # NE 20-0013

Supersedes

TN # NE 19-0011

Approval Date 12/18/2020 Effective Date July 1, 2020

Substitute per letter dated 8/21/01

ATTACHMENT 4.19-B  
Item 2c, Page 4

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State Nebraska  
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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Payment for Telehealth Services: Payment for the professional service performed by the distant site practitioner (i.e., where the expert physician or practitioner is physically located at time of telehealth encounter) will be equal to what would have been paid without the use of telehealth. If a core service is provided via telehealth and the center/clinic is the distant site, the FQHC will be reimbursed at the PPS or the APM encounter rate (whichever was chosen at the time of the service). Non FQHC services provided via telehealth would not be eligible for PPS/APM payment. Non-FQHC services will be paid according to the Nebraska Medicaid Physician and Mental Health and Substance Use Fee Schedule, as authorized elsewhere in the plan.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The provider must be in compliance with the standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of Telehealth services. Telehealth transmission cost and originating site fee are found on the Physician and Mental Health and Substance Use Fee Schedules, as authorized elsewhere in the plan.

The agency's fee schedule rate was set as of July 1, 2020 and is effective for telehealth transmission cost and originating site services provided on or after that date. All rates are published on the agency's website at <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the fee schedule for the specific program and year.

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TN # NE 20-0013

Supersedes

TN # NE 19-0011

Approval Date 12/18/2020 Effective Date July 1, 2020

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State Nebraska  
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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OTHER LABORATORY AND X-RAY SERVICES

Anatomical Laboratory Services

For dates of service on or after August 1, 1989, Nebraska Medicaid pays for anatomical laboratory services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Physician or Clinical Laboratory Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
  - a. The unit value multiplied by the conversion factor;
  - b. The invoice cost (indicated as "IC" in the fee schedule);
  - c. The maximum allowable dollar amount; or
  - d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).  
When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2020, and are effective for anatomical laboratory services on or after that date. All rates are published at: <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the fee schedule for the specific program and year.

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TN # NE 20-0013

Supersedes

TN # NE 19-0011

Approval Date 12/18/2020 Effective Date July 1, 2020



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State Nebraska  
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

---

Clinical Diagnostic Laboratory Services

Clinical diagnostic laboratory services, including collection of laboratory specimens by venipuncture or catheterization, is paid based on the fee schedule determined by Medicare.

The fee schedule amounts for Clinical Laboratory services are based on 100% Medicare Clinical Laboratory Fee Schedule. The Department shall update the Clinical Laboratory fee schedule using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

X-Ray Services

For dates of service on or after August 1, 1989, Nebraska Medicaid pays a claim for both the technical and professional components of x-ray services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Physician Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as -
  - a. The unit value multiplied by the conversion factor;
  - b. The invoice cost (indicated as "IC" in the fee schedule);
  - c. The maximum allowable dollar amount; or
  - d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).  
When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year. Updates are adjusted based on the Medicare fee schedule.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2020, and are effective for radiology services on or after that date. All rates are published at: <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the fee schedule for the specific program and year.

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TN # NE 20-0013

Supersedes

TN # NE 19-0011

Approval Date 12/18/2020 Effective Date July 1, 2020

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State Nebraska  
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES

For EPSDT services provided on or after April 1, 1990, the following applies.

For services reimbursed under the Nebraska Medicaid Practitioner Fee Schedule, Nebraska Medicaid pays for EPSDT services (except for clinical diagnostic laboratory services) at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Mental Health and Substance Use Fee Schedule for that date of service. The allowable amount is indicated in the fee schedule as -
  - a. The unit value multiplied by the conversion factor;
  - b. The invoice cost (indicated as "IC" in the fee schedule);
  - c. The maximum allowable dollar amount; or
  - d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

Reimbursement for services is based upon a Medicaid fee schedule established by the State of Nebraska. Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers of substance use services. The agency's fee schedule rate was set as of July 1, 2020 and is effective for EPSDT substance use services provided on or after that date. All rates are published on the agency's website at <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the fee schedule for the specific program and year.

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TN # NE 20-0013

Supersedes

TN # NE 19-0011

Approval Date 12/18/2020 Effective Date July 1, 2020

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State: Nebraska  
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

---

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Except for Clinical Laboratory services and Injectable Drugs, the agency's rates were set as of July 1, 2020, and are effective for EPSDT services on or after that date. All rates are published at: <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the fee schedule for the specific program and year.

Other services covered as EPSDT follow-up services will be paid according to currently established payment methodologies, i.e., inpatient hospital treatment for substance use treatment services will be paid according to the methodology in Attachment 4.19-A.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rates for the comparable in-person service.

Payment for Telehealth Transmission costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

Medicaid reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission shall be in compliance with the quality standards for real time, two-way interactive audiovisual transmission as set forth in state regulations as amended.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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Other Licensed Practitioners: Licensed Alcohol and Drug Counselor (LADC)

Rehabilitation Services - 42 CFR 440.130(d): Day Treatment/Intensive Outpatient Service by Direct Care Staff; Community Treatment Aide; Professional Resource Family Care; Therapeutic Group Home; Multisystemic Therapy; Functional Family Therapy; and Peer Support.

Reimbursement for services is based upon a Medicaid fee schedule established by the State of Nebraska. Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers of substance use services. The agency's fee schedule rate was set as of July 1, 2020, and is effective for mental health and substance use services provided on or after that date. All rates are published on the agency's website at <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the Mental Health and Substance Use fee schedule for the specific program and year.

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TN No. NE 20-0013

Supersedes

TN No. NE 19-0011

Approval Date 12/18/2020

Effective Date July 1, 2020

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State Nebraska  
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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FAMILY PLANNING SERVICES

For dates of service on or after August 1, 1989, Nebraska Medicaid pays for family planning services and supplies for individuals of child-bearing age at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Physician Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
  - a. The unit value multiplied by the conversion factor;
  - b. The invoice cost (indicated as "IC" in the fee schedule);
  - c. The maximum allowable dollar amount; or
  - d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2020, and are effective for family planning services on or after that date. All rates are published at: <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the fee schedule for the specific program and year.

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TN # NE 20-0013

Supersedes

TN # NE 19-0011

Approval Date 12/18/2020 Effective Date July 1, 2020

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State Nebraska  
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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PHYSICIANS' SERVICES

For dates of service on or after August 1, 1989, Nebraska Medicaid pays for covered physicians' services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Physician Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
  - a. The unit value multiplied by the conversion factor;
  - b. The invoice cost (indicated as "IC" in the fee schedule); or
  - c. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.
3. Exception: The Director of the Division of Medicaid and Long-Term Care or designee may enter into an agreement for a negotiated rate with an out-of-state provider which will be based on a percentage of billed charges, not to exceed 100%, only when the Medical Director of the Division has determined that:
  - a. The client requires specialized services that are not available in Nebraska; and
  - b. No other source of the specialized service can be found.

The following is a listing of specialized physician services that have been previously rendered by out-of-state providers:

- a. lung transplants; and
- b. pediatric heart transplants.

Note: The above listing is not all-inclusive of the specialized physician services that will be reimbursed via negotiated rates in the future, as it is based on previous experience.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of physicians' services. The agency's fee schedule rate was set as of July 1, 2020 and is effective for physician services provided on or after that date. All rates are published on the agency's website at <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the fee schedule for the specific program and year.

Physicians and non-physician care providers are subject to a site-of-service payment adjustment. A site-of-service differential that reduces the fee schedule amount for specific CPT/HCPCS codes will be applied when the service is provided in the facility setting. Based on the Medicare differential, Nebraska Medicaid will reimburse specific CPT/HCPCS codes with adjusted rates based on the site-of-service.

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TN # NE 20-0013

Supersedes

Approval Date 12/18/2020 Effective Date July 1, 2020

TN # NE 19-0011

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State Nebraska  
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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SMOKING CESSATION

Smoking cessation services rendered via common procedural terminology (CPT) codes 99406 and 99407 are reimbursed on a fee schedule.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended. Telehealth transmission cost and originating site fee are found on the Physician and Mental Health and Substance Use Fee Schedules, as authorized elsewhere in the plan.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2020, and are effective for smoking cessation services on or after that date. All rates are published at: <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the Mental Health and Substance Use fee schedule for the specific program and year.

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TN # NE 20-0013

Supersedes

TN # NE 19-0011

Approval Date 12/18/2020 Effective Date July 1, 2020

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State Nebraska  
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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PODIATRISTS' SERVICES

Nebraska Medicaid pays for covered podiatry services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Podiatry Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
  - a. The unit value multiplied by the conversion factor;
  - b. The invoice cost (indicated as "IC" in the fee schedule);
  - c. The maximum allowable dollar amount;
  - d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2020, and are effective for podiatrists' services on or after that date. All rates are published at: <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the fee schedule for the specific program and year.

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TN # NE 20-0013

Supersedes

TN # NE 19-0011

Approval Date 12/18/2020 Effective Date July 1, 2020



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State Nebraska  
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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OPTOMETRISTS' SERVICES

Nebraska Medicaid pays for covered optometrists' services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Vision Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
  - a. The unit value multiplied by the conversion factor;
  - b. The invoice cost (indicated as "IC" in the fee schedule) - the provider's actual cost (including discounts) from the provider's supplier. The maximum invoice cost payable is limited to reasonable available cost;
  - c. The maximum allowable dollar amount; or
  - d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2020, and are effective for optometrists' services on or after that date. All rates are published at: <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the fee schedule for the specific program and year.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State Nebraska  
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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CHIROPRACTIC SERVICES

Nebraska Medicaid pays for covered chiropractic services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Chiropractic Fee Schedule in effect for that date of service.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2020, and are effective for chiropractic services on or after that date. All rates are published at: <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the fee schedule for the specific program and year.

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State Nebraska  
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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HOME HEALTH SERVICES

Nebraska Medicaid pays for medically prescribed and Department approved home health agency services provided by Medicare-certified home health agencies. The Department may request a cost report from any participating agency.

For dates of service on or after July 1, 1990, Medicaid pays for home health agency services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for each respective procedure in the Nebraska Medicaid Home Health Agency Fee Schedule in effect for that date of service.

Payment for supplies normally carried in the nursing bag and incidental to the nursing visit is included in the per visit rate. Medical supplies not normally carried in the nursing bag are provided by pharmacies or medical suppliers who bill Medicaid directly. Under extenuating circumstances, the home health agency may bill for a limited quantity of supplies.

Nebraska Medicaid applies the following payment limitations:

Brief services are performed by a home health or private-duty nursing service provider to complete the client's daily care in a duration of 15 minutes to two hours per visit, when medically necessary. The services may be divided into two or more trips.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2020, and are effective for home health services on or after that date. All rates are published at: <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the fee schedule for the specific program and year.

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State Nebraska  
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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## HOME HEALTH SERVICES

Extended Services are performed by a home health or private-duty nursing service provider when the client's needs cannot be appropriately met within the Brief Service limitation of two hours or less.

Medicaid applies the following payment limitations to nursing services (RN and LPN) for adults age 21 and older:

- a. Per diem reimbursement for nursing services for the care of ventilator-dependent clients are paid at the lower of:
  1. The provider's submitted charge;
  2. The allowable amount for each respective procedure in the Nebraska Medicaid Home Health Agency Fee Schedule in effect for that date of service; or
  3. The average ventilator-dependent per diem of all Nebraska nursing facilities which are providing that service. This average per diem shall be computed using nursing facility's ventilator rates which are effective July 1 of each year, and are applicable for that state fiscal year period.
  
- b. Per diem reimbursement for all other in-home nursing services are paid at the lower of:
  1. The provider's submitted charge;
  2. The allowable amount for each respective procedure in the Nebraska Medicaid Home Health Agency Fee Schedule in effect for that date of service; or
  3. The Extensive Services 2 case-mix reimbursement level. This average shall be computed using the Extensive Services 2 case-mix nursing facility rates which are effective July 1 of each year, and applicable for that state fiscal year period.

Under special circumstances, the per diem reimbursement may exceed this maximum for a short period of time - for example, a recent return from a hospital stay. However, in these cases, the 30 day average of the in-home nursing per diems shall not exceed the maximum above. (The 30 days are defined to include the days which are paid in excess of the maximum plus those days immediately following, totaling 30.) When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2020, and are effective for home health services on or after that date. All rates are published at: <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the fee schedule for the specific program and year.

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State Nebraska  
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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MEDICAL SUPPLIES, EQUIPMENT, AND APPLIANCES FOR SUITABLE USE IN THE HOME

Nebraska Medicaid pays for covered durable medical equipment, medical supplies, orthotics and prosthetics, at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid DMEPOS Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
  - a. The unit value multiplied by the conversion factor;
  - b. The invoice cost (indicated as "IC" in the fee schedule);
  - c. The maximum allowable dollar amount; or
  - d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.
3. For DMEPOS items associated with Section 1903(i)(27) of the Social Security Act, amended by Section 5002 of the 21 Century Cures Act, and identified by the Centers of Medicare and Medicaid Services (CMS) as covered by Medicare, Medicaid will pay the lower of the following: (1) The Medicare DMEPOS fee schedule rate for Nebraska geographic, non-rural areas, set as of January 1 of each year, which will be reviewed on a quarterly basis and updated as Medicare updates the fee schedule; (2) the Medicare competitive bidding program rate for the specific item of DME, or (3) the provider's billed charges.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2020, and are effective for medical supplies, equipment, and applications services on or after that date. All rates are published at: <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the fee schedule for the specific program and year.

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State Nebraska  
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

---

CLINIC SERVICES

Nebraska Medicaid pays for clinic services and outpatient mental health services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Mental Health and Substance Use Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
  - a. The unit value multiplied by the conversion factor;
  - b. The invoice cost (indicated as "IC" in the fee schedule);
  - c. The maximum allowable dollar amount; or
  - d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2020, and are effective for clinic services on or after that date. All rates are published at: <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the fee schedule for the specific program and year.

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State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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Pediatric Feeding Disorder Clinic Intensive Day Treatment: Reimbursement for pediatric feeding disorder clinic intensive day treatment for medically necessary services will be a bundled rate based on the sum of the fee schedule amounts for covered services provided by Medicaid enrolled licensed practitioners. This service is reimbursed via a daily rate.

Pediatric Feeding Disorder Clinic Outpatient Treatment: Reimbursement for Pediatric Feeding Disorder Clinic Outpatient Treatment for medically necessary services will be based on the appropriate fee schedule amount for a physician consultation. This service is reimbursed via an encounter rate.

An encounter means a face-to-face visit between a Medicaid-eligible patient and a physician, psychologist, speech therapist, physical therapist, or dietician during which services are rendered. Encounters with more than one health professional and multiple encounters with the same health professional which take place on the same day and at a single location constitute a single visit.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of pediatric feeding disorder services. The agency's fee schedule rate was set as of July 1, 2020 and is effective for pediatric feeding disorder services provided on or after that date. All rates are published on the agency's website at <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the Pediatric Feeding Clinics' fee schedule for the specific program and year.

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State Nebraska  
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

---

DENTAL SERVICES

For dates of service on or after August 1, 1989, Nebraska Medicaid pays for dental services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Dental Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as -
  - a. The unit value multiplied by the conversion factor;
  - b. The invoice cost (indicated as "IC" in the fee schedule);
  - c. The maximum allowable dollar amount; or
  - d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2020 and are effective for dental services on or after that date. All rates are published at: <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the fee schedule for the specific program and year.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State Nebraska  
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

---

PHYSICAL THERAPY

For dates of service on or after August 1, 1989, Nebraska Medicaid pays for physical therapy services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Physical Therapy and Occupational Therapy Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
  - a. The unit value multiplied by the conversion factor;
  - b. The invoice cost (indicated as "IC" in the fee schedule);
  - c. The maximum allowable dollar amount; or
  - d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2020 and are effective for physical therapy services on or after that date. All rates are published at: <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the fee schedule for the specific program and year.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

---

OCCUPATIONAL THERAPY

Nebraska Medicaid pays for occupational therapy services provided by independent providers at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Physical Therapy and Occupational Therapy Fee Schedule for that date of service. The allowable amount is indicated in the fee schedule as:
  - a. The unit value multiplied by the conversion factor;
  - b. The invoice cost (indicated as "IC" in the fee schedule);
  - c. The maximum allowable dollar amount; or
  - d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" – by report or "RNE" - rate not established in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2020 and are effective for occupational therapy services on or after that date. All rates are published at: <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the fee schedule for the specific program and year.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

---

SERVICES FOR INDIVIDUALS WITH SPEECH, HEARING, AND LANGUAGE DISORDERS  
(PROVIDED BY OR UNDER THE SUPERVISION OF A SPEECH PATHOLOGIST OR  
AUDIOLOGIST)

For dates of service on or after August 1, 1989, Nebraska Medicaid pays for services for individual with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist) at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Speech Pathology and Audiology Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
  - a. The unit value multiplied by the conversion factor;
  - b. The invoice cost (indicated as "IC" in the fee schedule);
  - c. The maximum allowable dollar amount; or
  - d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of Medicare rate, the rate is determined as the average of available rates from other states.

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2020 and are effective for services for individuals with speech, hearing, and language disorders on or after that date. All rates are published at: <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the fee schedule for the specific program and year.

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State Nebraska  
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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DENTURES

For dates of service on or after August 1, 1989, Nebraska Medicaid pays for dentures at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Dental Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
  - a. The unit value multiplied by the conversion factor;
  - b. The invoice cost (indicated as "IC" in the fee schedule);
  - c. The maximum allowable dollar amount; or
  - d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2020 and are effective for denture services on or after that date. All rates are published at: <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the fee schedule for the specific program and year.

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State Nebraska  
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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PROSTHETIC DEVICES

Nebraska Medicaid pays for covered durable medical equipment, medical supplies, orthotics and prosthetics, at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid DMEPOS Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
  - a. The unit value multiplied by the conversion factor;
  - b. The invoice cost (indicated as "IC" in the fee schedule);
  - c. The maximum allowable dollar amount; or
  - d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.
3. For DMEPOS items associated with Section 1903(i)(27) of the Social Security Act, amended by Section 5002 of the 21 Century Cures Act, and identified by the Centers of Medicare and Medicaid Services (CMS) as covered by Medicare, Medicaid will pay the lower of the following: (1) The Medicare DMEPOS fee schedule rate for Nebraska geographic, non-rural areas, set as of January 1 of each year, which will be reviewed on a quarterly basis and updated as Medicare updates the fee schedule; (2) the Medicare competitive bidding program rate for the specific item of DME, or (3) the provider's billed charges.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2020 and are effective for prosthetic device services on or after that date. All rates are published at: <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the fee schedule for the specific program and year.

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State Nebraska  
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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EYEGASSES

Nebraska Medicaid pays for covered eyeglasses at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Vision Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
  - a. The unit value multiplied by the conversion factor;
  - b. The invoice cost (indicated as "IC" in the fee schedule) - the provider's actual cost (including discounts) from the provider's supplier. The maximum invoice cost payable is limited to reasonable available cost;
  - c. The maximum allowable dollar amount; or
  - d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" by report or "RNE" rate not established in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2020 and are effective for eyeglass services on or after that date. All rates are published at: <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the fee schedule for the specific program and year.

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State Nebraska  
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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SCREENING SERVICES

Nebraska Medicaid pay for covered screening services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Physician Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
  - a. The unit value multiplied by the conversion factor;
  - b. The invoice cost (indicated as "IC" in the fee schedule);
  - c. The maximum allowable dollar amount; or
  - d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2020 and are effective for screening services on or after that date. All rates are published at: <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the fee schedule for the specific program and year.

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State Nebraska  
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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SECURE PSYCHIATRIC RESIDENTIAL REHABILITATION

Medicaid has researched the cost of an existing similar service to develop a comparable rate. Costs for treatment and rehabilitation services are contained in the Medicaid rate. The rate does not include room and board. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Secure Psychiatric Residential Rehabilitation Services. The agency's fee schedule rate was set as of July 1, 2020 and is effective for secure psychiatric residential rehabilitation services provided on or after that date. All rates are published at <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the Mental Health and Substance Use fee schedule for the specific program and year.

The State Medicaid agency will have an agreement with each entity receiving payment under Secure Psychiatric Residential Rehabilitation services that will require that the entity furnish to the Medicaid agency on an annual basis the following:

- Data, by practitioner, on the utilization by Medicaid beneficiaries of the services included in the unit rate,
- Cost information by practitioner type and by type of service actually delivered within the services unit,
- Provider's annual utilization data and cost information shall support that the required type, quantity and intensity of treatment services are delivered to meet the medical needs of the clients served. Medicaid Agency or its designee may further evaluate through on site or post pay review of the treatment plans and the specific services delivered as necessary to assure compliance.

COMMUNITY SUPPORT SERVICES

Community Support Services shall be reimbursed on a direct service by service basis and billed in 15 minute increments up to a maximum of 144 units per 180 days.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of community support services. The agency's fee schedule rate was set as of July 1, 2020 and is effective for community support services provided on or after that date. All rates are published on the agency's website at <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the Mental Health and Substance Use fee schedule for the specific program and year.

This rate will be the same for quasi-governmental and private providers of community support service.

The rate includes all indirect services and collateral contacts that are medically necessary rehabilitative related interventions.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State Nebraska  
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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PEER SUPPORT

Peer Support shall be reimbursed on a direct service by service basis and billed in 15 minute increments.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Peer Support services. The agency's Mental Health and Substance Use fee schedule rate for Peer Support will be set as of July 1, 2020 and is effective for services provided on or after that date. All rates are published on the agency's website at <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the fee schedule for the specific program and year.

This rate will be the same for quasi-governmental and private providers of community support service.

OPIOID TREATMENT PROGRAM (OTP)

When services are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's OTP rates on the Mental Health and Substance Use fee schedule will be set as of January 1, 2020, and will be effective for services provided on or after that date. All rates are published on the agency's website at <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the fee schedule for the specific program and year.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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EXTENDED SERVICES TO PREGNANT WOMEN

For dates of service on or after August 1, 1989, Nebraska Medicaid pays for extended services to pregnant women at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Physician Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
  - a. The unit value multiplied by the conversion factor;
  - b. The invoice cost (indicated as "IC" in the fee schedule);
  - c. The maximum allowable dollar amount; or
  - d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2020 and are effective for extended services to pregnant women on or after that date. All rates are published at: <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the fee schedule for the specific program and year.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State Nebraska  
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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AMBULATORY PRENATAL CARE FOR PREGNANT WOMEN FURNISHED DURING A PRESUMPTIVE ELIGIBILITY PERIOD

For dates of service on or after August 1, 1989, Nebraska Medicaid pays for ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a Medicaid-enrolled provider at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Ambulatory Surgical Center and Physician Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
  - a. The unit value multiplied by the factor;
  - b. The invoice cost (indicated as "IC" in the fee schedule);
  - c. The maximum allowable dollar amount; or
  - d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule). When a code is without a modifier and is notated as BR/RNE, the code is manually priced to mirror the current year Medicare rate. In the absence of the Medicare rate, the rate is determined as the average of available rates from other states.

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2020 and are effective for ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period on or after that date. All rates are published at: <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the fee schedule for the specific program and year.

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State Nebraska  
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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PERSONAL CARE AIDE SERVICES

For services provided on or after July 1, 1998. Nebraska Medicaid pays for personal care aide services at the lower of:

1. The provider's submitted charge: or
2. The allowable amount for that procedure code the Nebraska Medicaid Care Aide Fee Schedule.

Personal Assistance Services will be reimbursed at rates established and published by Nebraska Health and Human Services. Rates are based on experience or training of the Personal Assistance provider.

For purpose of establishing the provider payment rate. Nebraska Medicaid considers a provider of personal assistance services to be "specialized" the provider meets one of the following criteria and presents a copy of the certificate or license to the worker. The provider must:

1. Have successfully completed the American Red Cross Home-Bound Care Course or a basic aide training course that has been approved by the Nebraska Health and Human Services System;
2. Have passed the Nurse Aide Equivalency test;
3. Be a licensed R.N. or L.P.N: or
4. Have a total of 4160 hours of experience as a personal assistance service provider.

When services which are reimbursed per a fee schedule, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of July 1, 2020 and are effective for personal care aide services provided on or after that date. All rates are published on the agency's website at: <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the Personal Assistance fee schedule for the specific program and year.

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State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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FREESTANDING BIRTH CENTER SERVICES

Nebraska Medicaid providers of birthing center services are reimbursed based on a fee schedule as follows:

- a. Payment for birthing center services provided by a participating, licensed birthing center is limited to the allowable rates established by Nebraska Medicaid.
- b. The fee schedule established by Nebraska Medicaid is based upon a review of Medicaid fees paid by other states;
- c. The birthing center and the birth attendant must bill separately for the services provided by each. The birthing center may bill only for facility services outlined elsewhere in this state plan.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of freestanding birthing center services. The agency's fee schedule rate was set as of July 1, 2020 and is effective for freestanding birthing center services provided on or after that date. All rates are published on the agency's website at <http://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx>. From the landing page, scroll down to the Free Standing Birth Centers' fee schedule for the specific program and year.

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